Agency _____ Agency #

SUPERVISOR'S REPORT OF INDUSTRIAL INJURY

ORIGINAL COPY TO AGENCY
WORKERS' COMPENSATION COORDINATOR

Employee Name _____

Home Address _____ Zip Code _____

Birth Date ____/____/____ Social Security # _____

Job: Title: _____ Marital Status

Date of Hire _____ Home Phone # _____

Injury Date ____/____/____ Time _____ AM PM

Nature of Injury _____ (scratch, cut, bruise, etc.) Part of Body _____ (finger, hand, ankle, etc.)

Name of Dr. or Hospital _____

Location of Incident _____

_____

How did accident happen? (State specific job being done and what went wrong. Include machine / tool or object connected with accident.)

_____

_____

_____

Actions necessary to Prevent Reoccurrence _____

_____

_____

If accident was caused by non-state employee or by faulty equipment, give name and address.

_____

_____

List witnesses to accident _____

_____

Was personal protective equipment being worn? ..... ☐ YES ☐ NO

If yes, what type? (check one or more items below.)

- ☐ Protective Clothing
- ☐ Foot Protection
- ☐ Eye Protection
- ☐ Head Protection
- ☐ Seat Belts
- ☐ Hearing Protection
- ☐ Respirator
- ☐ Back Support Belt
- ☐ Other (explain) _____

Is use of personal protective equipment required for this job? ... ☐ YES ☐ NO

_____

EMPLOYEE'S SIGNATURE DATE REPORTED

_____

SUPERVISOR'S SIGNATURE (Please Print) PHONE #

WHITE - To Agency Workers' Compensation Coordinator — PINK - Loss Prevention
BLUE - Doctor's Copy — YELLOW - Supervisor's Copy

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